



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

ELITE HEALTHCARE FORT WORTH

**Respondent Name**

ACE AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-14-2738-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

MAY 8, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** During a team conference the treating provider is not present. Here is the description of CPT 99361 that is followed with W1 modifier. Team member are not to be employees of the treating provider, in our case they are not. They are employees of Elite Healthcare just like the treating provider, Dr. Lopez is an employee of Elite Healthcare. Documentation must show: purpose and outcome. Name and specialty of individuals attending conference. Team conferences are to be done every 30 days."

**Amount in Dispute:** \$113.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The medical bill received for the date of service 1/31/14 shows Michael Lopez, D.C. as the physician who supplied the services. However, the documentation does not show that Michael Lopez, D.C. attended the team conference. The documentation specifically says 'Healthcare professionals participating in conference' are as follows: Steve Silvey, P.T.; Jacqueline Allender, LMT; Yesenia Pedroza, CA; Alivia Lopez, CA; and Sigal Lazalde, CA. Each one of them signed the documentation. Michael Lopez, D.C. did not sign the documentation as a participant. Therefore, the documentation does not support the services billed."

**Response Submitted By:** Downs Stanford, P.C.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2014	CPT Code 99361-W1 Case Management Services	\$113.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- B1, B12-Services not documented in patients medical records.
  - W3-Request for reconsideration.
  - 193- Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

### **Issues**

Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?

### **Findings**

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason code "B12"

28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added.

Review of the submitted TEAM CONFERENCE report finds that the requestor listed the participants in the conference; however, the record does not support the treating doctor was present and it does not meet requirements outlined in 28 Texas Administrative Code §134.204(e)(2) and (4). As a result, reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

01/23/2015  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**